

# UC Berkeley

## UC Berkeley Previously Published Works

**Title**

Empathy and patient-physician conflicts.

**Permalink**

<https://escholarship.org/uc/item/0vn45527>

**Journal**

Journal of general internal medicine, 22(5)

**ISSN**

0884-8734

**Author**

Halpern, Jodi

**Publication Date**

2007-05-01

**DOI**

10.1007/s11606-006-0102-3

Peer reviewed

# Empathy and Patient–Physician Conflicts

Jodi Halpern, MD, PhD

Joint Medical Program/School of Public Health, University of California, Berkeley, 570 University Hall, Berkeley, CA 94705, USA.

Physicians associate empathy with benevolent emotions and with developing a shared understanding with patients. While there have been many articles on managing “difficult” patients, little attention has been paid to the challenges physicians face during conflicts with patients, especially when both parties are angry and yet empathy is still needed. This topic is especially important in light of recent studies showing that practicing medicine increasingly requires physicians to manage their own feelings of anger and frustration. This article seeks to describe how physicians can learn to empathize with patients even when they are both subject to emotions that lead to interpersonal distancing. Empathy is defined as engaged curiosity about another’s particular emotional perspective. Five specific ways for physicians to foster empathy during conflict are described: recognizing one’s own emotions, attending to negative emotions over time, attuning to patients’ verbal and nonverbal emotional messages, and becoming receptive to negative feedback. Importantly, physicians who learn to empathize with patients during emotionally charged interactions can reduce anger and frustration and also increase their therapeutic impact.

**KEY WORDS:** doctor-patient relationships; communications skills; professionalism; patient-centered care; empathy.

DOI: 10.1007/s11606-006-0102-3

© 2007 Society of General Internal Medicine 2007;22:696–700

## INTRODUCTION

A 58-year-old athletic businessman, suddenly paralyzed from the neck down with (potentially reversible) Guillan–Barre syndrome, is refusing necessary care because he sees the doctors and nurses as “incompetent.” The whole intensive care team is fed up with him and his wife and daughters are panicked.

A 19-year-old is blocking the door to his dying mother’s room and threatening to shoot the

oncology nurses if they give his mother more sedating pain medication. He can’t stand the idea of losing contact with her. The entire team is terrified of him and furious.

Clinical accounts of patient–physician conflicts often focus on managing difficult patients.<sup>1–4</sup> Articles on conflict that do explore physicians’ negative emotions<sup>5,6</sup> or take a conflict-resolution approach<sup>7–10</sup> recommend that physicians empathize with patients or family members. However, there is virtually no literature in medicine about *how* physicians can empathize with their patients during conflicts that evoke their own anger or other negative emotions.<sup>11</sup> This article seeks to bring together theoretical work, research findings from the social sciences, clinical studies, and observations by a psychiatrist from consultation-liaison work (JH) to suggest some basic skills that physicians can develop to maintain empathy when they are involved in overt conflict or otherwise experiencing negative feelings towards patients.

Outside of medicine, the term “empathy” commonly refers to a complex affective–cognitive activity involving emotional attunement and imagining how another person feels<sup>12–14</sup> but, in medicine, traditionally refers to a purely cognitive understanding of patients’ emotions—a special professional “detached concern.”<sup>15,16</sup> Detachment has been viewed as necessary for objectivity, for avoiding burnout,<sup>17,18</sup> and especially for avoiding negative emotions during doctor–patient conflicts.

Today, however, the ideal of detached concern is being replaced by the goal of emotional attunement, and thus of complex affective–cognitive empathy.<sup>18–23</sup> There is increasing evidence that emotionally engaged physicians have greater therapeutic efficacy.<sup>24–30</sup> Engagement generates more trust, leading directly to improved patient adherence to treatment.<sup>24,31–34</sup> Emotionally engaged physicians communicate more effectively, decreasing patient anxiety and improving patients’ coping, leading to better outcomes.<sup>35–38</sup> Patients disclose more to emotionally attuned physicians,<sup>19,39,40</sup> who are more sensitive to individual differences and able to recognize atypical problems that might otherwise be missed.<sup>15,41–45</sup> Conversely, a lack of empathy increases patient dissatisfaction and the risk of malpractice suits.<sup>33,46</sup>

However, despite the shift toward emotional empathy,<sup>47–49</sup> detachment remains the norm in doctor–patient conflicts.<sup>1,50–52</sup> I use the term “conflict” here to identify not only overt disagreements, but also a broad range of situations in which physicians face role conflicts due to feeling negatively towards patients. Physicians especially need to be able to recognize submerged tensions. Some patients are reluctant to openly disagree with or question their physicians, fearing that decreased care might result.<sup>7,53,54</sup> Irritation with such patients may be the only clue of conflict.

---

*This work was supported by the Greenwall Foundation and the Berkeley Consortium on Population Health and Human Development, with funding from the National Institute of Mental Health (R21MH70950) and the Robert Wood Johnson Foundation Health & Society Scholars Program.*

*Received November 14, 2005*

*Revised July 26, 2006*

*Accepted December 4, 2006*

*Published online February 17, 2007*

How can physicians empathize when feeling negatively towards their patients?<sup>55-59</sup> General sympathy or concern does not appear to be enough, as highly charged situations—where patients refuse medically necessary care or have needs that are difficult to meet—appear to pose a particular challenge for sympathetic physicians.<sup>1,50-52,56,60</sup> Sympathy primarily involves feeling rather than cognition, and simply resonating emotionally with the patient is problematic when the main emotions are anger and frustration, which are among the most contagious affects.<sup>61</sup> Absent some clear skills to manage such feelings, physicians, like other human beings, readily become defensive and engage in counterproductive arguments,<sup>1,2,50-52,62-64</sup> ultimately escalating the conflict.<sup>65</sup>

For these reasons, traditional thinking has been that when negative emotions are involved, one can, at best, strive for a detached, intellectual understanding of another person's perspective.<sup>66</sup> However, psychology research shows that conflict also makes it more difficult to cognitively take another's perspective and that, ironically, an attitude of concern for another increases the difficulty of seeing things from their point of view during conflict.<sup>67-70</sup> Thus, during conflict, the concerned physician finds it difficult both to feel the right feelings and even to be able to see, intellectually, the patient's perspective. It is especially difficult to imagine how another feels when the other person is subject to negative emotions, such as anger or shame.<sup>66</sup> All of this suggests that physicians encounter difficult emotional and cognitive demands when trying to empathize during conflict. Yet these difficulties are worth addressing because full-blown empathy, both feeling with and cognitively imagining another person's perspective, is extremely valuable for conflict resolution because it encourages helping behavior and reduces anger.<sup>71</sup>

We can better address the challenge of empathizing during conflicts by widening our view of empathy to include not only spontaneous emotional attunement, which may not occur initially, but also a conscious process of cultivating curiosity about another's distinct perspective. While empathy is akin to sympathy in involving actual emotional receptivity, empathy is more complex, guided by cognitive as well as affective interest in another.<sup>15,72</sup> For sympathy, it is sufficient to resonate with another's general mood without becoming curious to learn more about another's particular point of view, whereas such curiosity is central to empathy. This distinction is crucial because empathy pushes one to appreciate that another sees things differently, whereas sympathy may blur such differences.<sup>15</sup>

Clinical empathy, in particular, aims for a more accurate view of what, precisely, is troubling the patient. Yet physicians, like other individuals, vary in their ability to imagine another person's thoughts and feelings, and some patients may be easier to "read" than others.<sup>73,74</sup> However, research has shown that empathic accuracy<sup>75</sup> is a trainable skill, which is improved by direct feedback and by an established relationship or desire for a future relationship with another.<sup>73,74,76</sup> Most importantly, combining curiosity with emotional engagement, more so than a detached intellectual grasp of another's situation, appears to correlate with improved empathic accuracy.<sup>77</sup>

This paper describes five skills for cultivating engaged curiosity about negative feelings, one's own and the patient's. Insofar as shutting down negative emotions also constricts the ability to remain engaged emotionally, the skills described below seek to avoid such shutdown. Instead, physicians are

encouraged to stay fully emotionally engaged during conflicts, in part by recognizing how even their negative feelings can be put to good therapeutic use.<sup>1,50-52</sup>

## RECOGNIZING ONE'S EMOTIONS IN REAL TIME

A crucial first step is for physicians to recognize their own feelings accurately. In contrast to many nurses and psychotherapists, physicians rarely learn to attune to their negative feelings.<sup>16,78,79</sup> Yet, evidence suggests that taking a few moments for self-awareness can reduce errors, improve decision-making, and resolve conflict.<sup>78-80</sup> Basic psychology research shows that once people recognize their negative emotions, they readily correct their negative appraisals and actively seek more information about their situation.<sup>81,82</sup>

## REFLECTING ON NEGATIVE EMOTIONS OVER TIME

The second step is for physicians to become curious about the meaning of negative feelings in themselves and their patients. Physicians are socialized against self-reflection,<sup>79,83,84</sup> yet preliminary research suggests that physicians can learn to examine of their own negative feelings and, in so doing, improve their clinical care and professional satisfaction.<sup>83,84</sup> Still, self-reflection does not automatically lead to curiosity about another's views, especially when that person causes distress. Psychotherapists bridge the two by becoming curious about what clues their own feelings provide about patients' feelings.<sup>85,86</sup> Recognizing and skillfully using this "countertransference" is considered key to psychiatric clinical competence,<sup>85,86</sup> and could become an identified core skill for other physicians as well.<sup>87,88</sup> In the example of the young man who was threatening to shoot the nurses, once the team learned that he had no gun nor any history of violence, psychiatric consultation helped the staff members recognize that some of their terror was based on their own personal fears of loss and their identification with this 19-year-old's intense grief.

## ATTUNING TO EMOTIONAL MESSAGES IN A PATIENT'S STORY

However, reflecting on what one's own feelings may reveal about another person is not yet empathy. A distinct step is to deliberately listen for the patient's distinct emotional concerns, which may be embedded in, yet hidden by, concrete clinical demands.<sup>63,64,72</sup> Observational research shows that physicians miss most opportunities for empathy by restricting attention to facts rather than to the emotional meanings of patients' words.<sup>39,89,90</sup> For example, when an 18-year-old athlete with severe bowel disease was refusing life-saving surgery because he could no longer be "active" in sports, most of his physicians became frustrated or furious and withdrew emotionally. One resident, sensing that this young man found it excruciating to discuss his fears with healthy, male doctors, arranged to have the patient meet with a female nurse who had a colostomy. In this meeting, the patient was able to disclose his fear that the surgery would prevent him from having an "active" sex life. The nurse was able to reassure him, and he decided to have the operation.

## ATTENDING TO NONVERBAL COMMUNICATION

Patients do not simply tell doctors what is most significant to them. Rather, they first give nonverbal hints that they have something important to say.<sup>19,37,38,40,91</sup> When physicians reciprocate at these critical moments, patients talk more fully about their concerns and give fuller histories.<sup>19,39,40,47</sup> A recent review of the literature concluded that both sensitivity to patients' nonverbal cues and appropriate nonverbal communication by physicians affect patient satisfaction and health outcomes.<sup>91</sup> Physicians demonstrate attentiveness by rapidly adjusting their own gestures, pauses, vocal tone, and interpersonal distance in coordination with the patient.<sup>19,91</sup> There has been little research on how the component behaviors of nonverbal communication can be taught.<sup>91</sup> However, one observational study suggests that these skills are mainly conveyed through role-modeling,<sup>92</sup> whereas another shows that training in communication skills improves students' abilities to establish rapport with patients.<sup>93</sup>

## ACCEPTING NEGATIVE FEEDBACK

Finally, for physicians to experience and convey empathy during conflicts, it is essential to learn to accept patients' feedback, even when it is negative and blaming. This last step runs counter to many ingrained qualities of medical culture.<sup>94–96</sup> During conflicts, physicians often become more controlling and less open to negative feedback.<sup>1,50–52</sup>

Despite the prevailing culture, physicians and psychotherapists recount how accepting criticism without becoming defensive provides a gateway to empathy, enabling patients to share more difficult feelings lying underneath their anger.<sup>62,97–99</sup> For example, when I allowed the man with Guillain-Barre syndrome to complain, uninterrupted, about how "useless" his caregivers were (including me), he felt heard. He then talked about his own feeling of being trapped in a useless body and was able to cry and begin grieving.<sup>100</sup> While little research has examined links between empathy and negative feedback, studies have shown that accepting blame and offering an apology, when appropriate, can influence patient satisfaction and reduce anger, and may even prevent malpractice claims.<sup>33,46,101,102</sup>

## DISCUSSION

Emotional conflicts offer special therapeutic opportunities. The same emotional resonance triggered during conflicts—when acknowledged—can become the basis for genuine empathy, through the act of taking the perspective of those in distress.<sup>71</sup> However, clinical empathy is not a panacea for resolving all conflicts. Some patients are outraged because of systems issues that are genuinely unjust, such as persistent racial disparities in health care.<sup>103–105</sup> Rarely, an enraged patient may be very disturbed or psychotic and need treatment.<sup>1</sup> Even so, an empathic medical team can likely provide more effective treatment.<sup>24</sup>

Physicians cannot will themselves to empathize during conflicts,<sup>66</sup> but they can cultivate an ongoing practice of engaged curiosity. Activities that help in this process include meditation, sharing stories with colleagues, writing about doctoring, reading books, and watching films conveying emotional complexity.<sup>78,106,107</sup> Empiric studies show that writing narratives from

the patient's imagined perspective helps physicians develop lasting empathy skills.<sup>72,108</sup> Brief, problem-focused workshops that use role-playing can help health professionals identify negative emotions encountered in difficult communication tasks, then develop skills to clearly communicate during these highly conflictual situations. Follow-up evaluations show that participating individuals feel increased confidence in handling difficult emotions in their practices.<sup>109</sup>

The recommended strategies are likely to be efficient as well as effective. Despite expectations to the contrary, allowing patients to talk uninterrupted at the beginning of an interview or eliciting psychosocial information add very little time to history-taking.<sup>110–112</sup> However, missed emotional "clues" extend the length of medical visits.<sup>39</sup> Physicians who do not pay attention to their own emotions are likely to pathologize, ignore, transfer, or discharge "difficult" patients, leading to costs in personnel time, legal expenses, and patient transfers.<sup>113</sup> Finally, we have increasing evidence that physicians who engage emotionally enjoy their work more over time, which likely contributes to providing better care.<sup>6,17,114</sup>

Medical training absent explicit training in handling negative emotions can lead to the deterioration of empathy.<sup>21–23,29,115,116</sup> Even with an explicit commitment to empathy as a core feature of professionalism, the on-the-job experience of medical training tacitly promotes detachment, objectivity, and self-interest.<sup>117,118</sup> Yet, it is possible to equate professionalism with recognizing negative, as well as positive, emotions. In one study, highly empathetic staff members recognized and reported hostile emotional responses to client aggression *but* did not act on such feelings because of their sense of "professionalism."<sup>119</sup> During clinical rotations, it is especially important that attendings actually model the skills of accepting and managing negative emotions to help trainees learn to truly maintain empathy over time.

## CONCLUSION

This article advocates cultivating engaged curiosity when conflict and negative emotions threaten to erode the patient-physician relationship. By learning to consciously accept and respond to negative emotions, we become more skilled individually and collectively at managing feelings that could otherwise be quite destructive.<sup>78,120</sup> When physicians develop the skill of transforming their own emotional reactions into empathy for patients' unspoken fears and suffering, they do much more than cure; they serve in the healing of their patients as persons.<sup>15,51,98,121</sup>

---

**Acknowledgement:** The author gratefully acknowledges Katie Hasson, Bob Arnold, Guy Micco, Julie Stein, and John Swartzberg for advice and comments on this work.

**Potential Financial Conflicts of Interest:** None disclosed.

**Corresponding Author:** Jodi Halpern, MD, PhD; Joint Medical Program/School of Public Health, University of California, Berkeley, 570 University Hall, Berkeley, CA 94705, USA (e-mail: jhalpern@berkeley.edu).

## REFERENCES

1. Makadon HJ, Gerson S, Ryback R. Managing the care of the difficult patient in the emergency unit. *JAMA*. 1984;252:2585–8.



2. Groves J. Taking care of the hateful patient. *N Engl J Med*. 1978;298(16):883-7.
3. Hahn SR, Thompson KS, Wills TA, Stern V, Budner NS. The difficult doctor-patient relationship: somatization, personality and psychopathology. *J Clin Epidemiol*. 1994;47(6):647-57.
4. Schafer S, Nowlis DP. Personality disorders among difficult patients. *Arch Fam Med*. 1998;7:126-9.
5. Jellenik MS, Todres ID, Catlin EA, Cassem EH, Slazman A. Pediatric intensive care training: confronting the dark side. *Crit Care Med*. 1993;21(5):775-9.
6. Maguire P, Pitceathly C. Managing the difficult consultation. *Clin Med*. 2003;3(6):532-7.
7. Back AL, Arnold RM. Dealing with conflict in caring for the seriously ill: "it was just out of the question". *JAMA*. 2005;293(11):1374-81.
8. Breen CM, Abernethy AP, Abbott KH, Tulskey JA. Conflict associated with decisions to limit life-sustaining treatment in intensive care units. *J Gen Intern Med*. 2001;16:283-9.
9. Goold SD, Williams B, Arnold RM. Conflicts regarding decisions to limit treatment. *JAMA*. 2000;283:909-14.
10. Kopelman AE. Understanding, avoiding, and resolving end-of-life conflicts in the NICU. *Mt Sinai J Med*. 2006;73:580-6.
11. Shapiro J, Lie D. Using literature to help physician-learners understand and manage "difficult" patients. *Acad Med*. 2000;75(7):765-8.
12. Margulies A. *The Empathic Imagination*. New York, NY: W.W. Norton & Co; 1989.
13. Lipps T. Empathy and aesthetic pleasure. Translated by K. Aschenbrenner. In: Aschenbrenner K, Isenberg A, eds. *Aesthetic Theories: Studies in the Philosophy of Art*. Englewood Cliffs, NJ: Prentice Hall; 1965:403-12.
14. Mehrabian A, Young AL, Sato S. Emotional empathy and associated individual differences. *Curr Psychol Res Rev*. 1988;7(3):221-40.
15. Halpern J. *From Detached Concern to Empathy: Humanizing Medical Practice*. New York, NY: Oxford University Press; 2001.
16. Fox R, Lief H. Training for "detached concern." In: Lief H, ed. *The Psychological Basis of Medical Practice*. New York, NY: Harper & Row; 1963.
17. Roter D, Stewart S, Putnam N, Lipkin M. Communication patterns of primary care physicians. *JAMA*. 1997;277:350-6.
18. Halpern J. What is clinical empathy? *J Gen Intern Med*. 2003;18:670-4.
19. Suchman A, Markakis K, Beckman H, Frankel R. A model of empathic communication in the medical interview. *JAMA*. 1997;277(8):678-82.
20. Skeff KM, Mutha S. Role models: guiding the future of medicine. *N Engl J Med*. 1998;339:2017.
21. Spencer J. Decline in empathy in medical education: how can we stop the rot? *Med Educ*. 2004;38:916-8.
22. Feighny KM, Arnold L, Monaco M, Munro S, Earl B. In pursuit of empathy and its relationship to physician communication skills: multidimensional empathy training for medical students. *Ann Behav Sci Med Educ*. 1998;5:13-21.
23. Marcus ER. Empathy, humanism and the professionalization process of medical education. *Acad Med*. 1999;74:1211-5.
24. Roter D, Hall J, Merisca R, Nordstrom B, Cretin D, Svarstad B. Effectiveness of interventions to improve patient compliance: a meta-analysis. *Med Care*. 1997;36(8):1138-61.
25. Kim SS, Kaplowitz S, Johnston MV. The effects of physician empathy on patient satisfaction and compliance. *Eval Health Prof*. 2004;27(3):237-51.
26. Kerse N, Buetow S, Mainous AG III, Young G, Coster G, Arroll B. Physician-patient relationship and medication compliance: a primary care investigation. *Ann Fam Med*. 2004;2:455-61.
27. Girgis A, Sanson-Fisher RW. Breaking bad news 1: current advice for clinicians. *J Behav Med*. 1998;24:53-9.
28. Girgis A, Sanson-Fisher RW. Breaking bad news: consensus guidelines for medical practitioners. *J Clin Oncol*. 1995;13:2449-56.
29. Hojat M, Gonnella JS, Manione S, et al. Empathy in medical students as related to academic performance, clinical competence and gender. *Med Educ*. 2002;36:522-7.
30. Easter DW, Beach W. Competent patient care is dependent upon attending to empathic opportunities presented during interview sessions. *Curr Surg*. 2004;61(3):313-8.
31. Beck R, Duaghtridge R, Sloane P. Physician-patient communication in the primary care office: a systematic review. *J Am Board Fam Pract*. 2002;15:25-38.
32. Butow P, Maclean M, Dunn S, Tattersall M, Boyer M. The dynamics of change: cancer patients' preferences for information, involvement and support. *Ann Oncol*. 1997;8:857-63.
33. Frankel RM. Emotion and the physician-patient relationship. *Motiv Emotion*. 1995;19:163-73.
34. Squier RW. A model of empathic understanding and adherence to treatment regimens in practitioner-patient relationships. *Soc Sci Med*. 1990;30:325-39.
35. Rietveld S, Prins P. The relationship between negative emotions and acute subjective and objective symptoms of childhood asthma. *Psychol Med*. 1998;28:407-15.
36. Frasure-Smith N, Lesperance F, Talajic M. The impact of negative emotions on prognosis following myocardial infarction: is it more than depression? *Health Psychol*. 1995;14:388-98.
37. Ptacek JT, Eberhardt TL. Breaking bad news: a review of the literature. *JAMA*. 1996;276(6):496-502.
38. Ptacek JT, Fries EA, Eberhardt TL, Ptacek JJ. Breaking bad news to patients: physicians' perceptions of the process. *Support Care Cancer*. 1999;7:113-20.
39. Levinson W, Gorawara-Bhat R, Lamb J. A study of patient clues and physician responses in primary care and surgical settings. *JAMA*. 2000;284(8):1021-7.
40. DiMatteo MR, Taranta A, Friedman HS, Prince LM. Predicting patient satisfaction from physicians' nonverbal communication skills. *Med Care*. 1980;18(4):376-87.
41. Borrell-Carrio F, Suchman AL, Epstein RM. The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. *Ann Fam Med*. 2004;2:576-82.
42. Ross CA. Childhood sexual abuse and psychosomatic symptoms in irritable bowel syndrome. *J Child Sex Abus*. 2005;14(1):27-38.
43. Handa M, Nukina H, Ando K, Kubo C. What does pain or discomfort in irritable bowel syndrome mean? *Dig Dis Sci*. 2004;49(4):575-8.
44. Graugaard PK, Holgersen K, Finset A. Communicating with alexithymic and non-alexithymic patients: an experimental study of the effect of psychosocial communication and empathy on patient satisfaction. *Psychother Psychosom*. 2004;73(2):92-100.
45. Przuntek H, Muller T, Riederer P. Diagnostic staging of Parkinson's disease: conceptual aspects. *J Neural Transm*. 2004;111(2):201-16.
46. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Intern Med*. 1994;154:1365-70.
47. Frankel RM. Relationship-centered care and the patient-physician relationship. *J Gen Intern Med*. 2004;19(11):1163-5.
48. Larson E, Yao X. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA*. 2005;293:1100-6.
49. Griffin SJ, Kinmonth AL, Veltman M, Gillard S, Grant J, Stewart M. Effect on health-related outcomes of interventions to alter the interaction between patients and practitioners: a systematic review of trials. *Ann Fam Med*. 2004;2:595-608.
50. Vanderford M, Stein T, Sheeler R, Skochelak S. Communication challenges for experienced clinicians: topics for an advanced communication curriculum. *Health Commun*. 2001;13(3):261-84.
51. Guill T. Recognizing and adjusting to barriers in doctor-patient communication. *Ann Intern Med*. 1989;111:51-7.
52. Hedrick H, Nelson R. Handling ethical conflicts in the clinical setting. *Semin Pediatr Surg*. 2001;10(4):192-7.
53. Weitzman PF, Weitzman EA. Promoting communication with older adults: protocols for resolving interpersonal conflicts and for enhancing interactions with doctors. *Clin Psychol Rev*. 2003;23:523-35.
54. Adler SR, McGraw SA, McKinlay JB. Patient assertiveness in ethnically diverse older women with breast cancer: challenging stereotypes of the elderly. *J Aging Stud*. 1998;12(4):331-50.
55. Levinson W, Gorawara-Bhat R, Dueck R, et al. Resolving disagreements in the patient-physician relationship. *JAMA*. 1999;282(15):1477-83.
56. Zuger A. Dissatisfaction with medical practice. *N Engl J Med*. 2004;350(1):69-75.
57. Rosenberg AJ, Rothbaum PA. Managing anger in a managed care age. *Med Econ*. 2004;81(9):23-5.
58. Longhurst MF. Angry patient, angry doctor. *Can Med Assoc J*. 1980;123:597-8.
59. Back AL, Arnold RM, Baile WF, Tulskey JA, Fryer-Edwards K. Approaching difficult communication tasks in oncology. *CA Cancer J Clin*. 2005;55:164-77.
60. Guill TE, Suchman AL. Uncertainty and control: learning to live with medicine's limitations. *Hum Med*. 1993;9:109-20.

61. **Jones TS, Bodtker A.** Mediating with heart in mind: emotion in mediation practice. *Negotiation J.* 2001;217-44.
62. **Winnicott D.** Hate in the counter-transference. *Int J Psychoanal.* 1949;30:69-74.
63. **Stone D, Patton B, Heen S, Fisher R.** *Difficult Conversations: How to Discuss what Matters Most.* New York, NY: Penguin Books; 1999.
64. **Wile D.** *After the Fight: Using Your Disagreements to Build a Stronger Relationship.* New York, NY: Guilford Publications; 1995.
65. **Thomas SP.** Anger: the mismanaged emotion. *Dermatol Nurs.* 2003;15:351-7.
66. **Duan C.** Being empathic: the role of motivation to empathize and the nature of target emotions. *Motiv Emotion.* 2000;24:29-49.
67. **Steins G.** Motivation in person perception: role of the other's perspective. *J Soc Psychol.* 2000;140(6):692-709.
68. **Steins G, Wicklund RA.** Perspective-taking, conflict, and press: drawing an E on your forehead. *Basic Appl Soc Psych.* 1996;18:319-46.
69. **Wicklund RA, Steins G.** Person perception under pressure: when motivation brings about egocentrism. In: Gollwitzer PM, Bargh JA, eds. *The Psychology of Action: Linking Cognition and Motivation to Behavior.* New York, NY: Guilford Press; 1996:511-28.
70. **Krauss RM, Morsella E.** Communication and conflict. In: Deutsch M, Coleman PT, eds. *The Handbook of Conflict Resolution: Theory and Practice.* San Francisco, CA: Jossey-Bass; 2000:131-43.
71. **Betancourt H.** Attribution-emotion processes in White's realistic empathy approach to conflict and negotiation. *Peace Confl.* 2004;10:369-80.
72. **Charon R.** Narrative medicine: a model for empathy, reflection, profession and trust. *JAMA.* 2001;286(15):1897-902.
73. **Marangoni C, Garcia S, Ickes W, Teng G.** Empathic accuracy in a clinically relevant setting. *J Pers Soc Psychol.* 1995;68(5):854-69.
74. **Ickes W, Marangoni C, Garcia S.** Studying empathic accuracy in a clinically relevant context. In: Ickes W, ed. *Empathic Accuracy.* New York, NY: Guilford Press; 1997:282-310.
75. **Ickes W, Simpson JA.** Managing empathic accuracy in close relationships. In: Ickes W, ed. *Empathic Accuracy.* New York, NY: Guilford Press; 1997:218-50.
76. **Ickes W.** Empathic accuracy. *J Pers.* 1993;61:587-610.
77. **Davis MH, Kraus LA.** Personality and empathic accuracy. In: Ickes W, ed. *Empathic Accuracy.* New York, NY: Guilford Press; 1997:144-68.
78. **Smith M, Hart G.** Nurses' responses to patient anger: from disconnecting to connecting. *J Adv Nurs.* 1994;20:643-51.
79. **Epstein R.** Mindful practice. *JAMA.* 1999;282(9):833-9.
80. **Shapiro S, Schwartz G, Bonner G.** Effects of mindfulness-based stress reduction on medical and premedical students. *J Behav Med.* 1998;21(6):581-99.
81. **Schwarz N, Clore G.** Mood, misattribution, and judgments of well-being: informative and directive functions of affective states. *J Pers Soc Psychol.* 1983;45(3):513-23.
82. **Schwarz N.** Emotion, cognition, & decision-making. *Cogn Emotion.* 2000;14(4):433-40.
83. **Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C.** Calibrating the physician: personal awareness and effective patient care. *JAMA.* 1997;278:502-9.
84. **Meier DE, Back AL, Morrison RS.** The inner life of physicians and care of the seriously ill. *JAMA.* 2001;286:3007-14.
85. **Gold JH.** Reflections on psychodynamic psychotherapy supervision for psychiatrists in clinical practice. *J Psychiatr Pract.* 2004;10(3):162-9.
86. **Buckley P, Karasu TB, Charles E.** Common mistakes in psychotherapy. *Am J Psychiatry.* 1979;136(12):1578-80.
87. **Marshall AA, Smith RC.** Physicians' emotional reactions to patients: recognizing and managing countertransference. *Am J Gastroenterol.* 1995;90(1):4-8.
88. **Smith RC.** Teaching interviewing skills to medical students: the issue of 'countertransference'. *J Med Educ.* 1984;59(7):582-8.
89. **Eide H, Frankel R, Haavarsen AC, Vaupel KA, Graugaard PK, Finset A.** Listening for feelings: identifying and coding empathic and potential empathic opportunities in medical dialogues. *Patient Educ Couns.* 2004;54(3):291-7.
90. **Wissow LS, Larson S, Anderson J, Hadjiisky E.** Pediatric residents' responses that discourage discussion of psychosocial problems in primary care. *Pediatrics.* 2005;115(6):1569-79.
91. **Roter DL, Frankel RM, Hall JA, Sluyter D.** The expression of emotion through nonverbal behavior in medical visits: mechanisms and outcomes. *J Gen Intern Med.* 2006;21:S28-34.
92. **Weissmann PF, Branch WT, Gracey CF, Haidet P, Frankel RM.** Role modeling humanistic behavior: learning bedside manner from the experts. *Acad Med.* 2006;81(7):661-7.
93. **Windish DM, Price EG, Clever SL, Magaziner JL, Thomas PA.** Teaching medical students the important connection between communication and clinical reasoning. *J Gen Intern Med.* 2005;20:1108-13.
94. **Fox R.** *Experiment Perilous: Physicians and Patients Facing the Unknown.* Philadelphia, PA: University of Pennsylvania Press; 1974.
95. **Leape L.** A systems analysis approach to medical error. *J Eval Clin Pract.* 1997;3(3):213-22.
96. **McIntyre N, Popper KB.** The critical attitude in medicine: the need for a new ethics. *Br Med J.* 1983;287:1919-23.
97. **Stein H.** *The Psychodynamics of Medical Practice.* Berkeley, CA: University of California Press; 1985.
98. **Kohut H.** Introspection, empathy and psychoanalysis. *J Am Psychoanal Assoc.* 1959;7:459-83.
99. **Havens L.** Participant Observation: The Psychotherapy Schools in Action. New York, NY: Jason Aronson; 1993.
100. **Halpern JL.** Empathy: using resonance emotions in the service of curiosity. In: Spiro HM, Peschel E, Curnen MG, St. James D, eds. *Empathy and the Practice of Medicine: Beyond Pills and the Scalpel.* New Haven, CT: Yale; 1993:160-73.
101. **McCord RS, Floyd MR, Lang F, Young V.** Responding effectively to patient anger directed at the physician. *Fam Med.* 2002;34(5):331-6.
102. **Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W.** Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA.* 2003;289(8):1001-7.
103. **Groman R, Ginsburg J.** American College of Physicians. Racial and ethnic disparities in health care: a position paper of the American College of Physicians. *Ann Intern Med.* 2004;141(3):226-32.
104. **LaVeist TA, Nickerson KJ, Bowie JV.** Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. *Med Care Res Rev.* 2000;57(Suppl 1):146-61.
105. **Moseley KL, Church A, Hempel B, Yuan H, Goold SD, Freed GL.** End-of-life choices for African-American and white infants in a neonatal intensive-care unit: a pilot study. *J Natl Med Assoc.* 2004;96(7):933-7.
106. **Charon R.** Narrative and medicine. *N Engl J Med.* 2004;350(9):862-4.
107. **Brady DW, Corbie-Smith G, Branch WT.** 'What's important to you?': the use of narratives to promote self-reflection and to understand the experiences of medical residents. *Ann Intern Med.* 2002;137(3):220-3.
108. **DasGupta S, Charon R.** Personal illness narratives: using reflective writing to teach empathy. *Acad Med.* 2004;79:351-6.
109. **Parle M, Maguire P, Heaven C.** The development of a training model to improve health professionals' skills, self-efficacy and outcome expectancies when communicating with cancer patients. *Soc Sci Med.* 1997;44(2):231-40.
110. **Langewitz W, Denz M, Keller A, Kiss A, Ruttimann S, Wossmer B.** Spontaneous talking time at start of consultation in outpatient clinic: cohort study. *Br Med J.* 2002;325:682-3.
111. **Marvel M, Doherty W, Weiner E.** Medical interviewing by exemplary family physicians. *J Fam Pract.* 1998;47(5):343-8.
112. **Branch WT, Malik TK.** Using 'windows of opportunities' in brief interviews to understand patients' concerns. *JAMA.* 1993;269(13):1667-8.
113. **Nightingale SD, Yarnold PR, Greenberg MS.** Sympathy, empathy and physician resource utilization. *J Gen Intern Med.* 1991;6:420-3.
114. **Wear D, Bickel J, eds.** *Educating for Professionalism: Creating a Culture of Humanism in Medical Education.* Iowa City, IA: University of Iowa Press; 2000.
115. **Bellini LM, Baime M, Shea JA.** Variation of mood and empathy during internship. *JAMA.* 2002;287(23):3143-6.
116. **Bellini LM, Shea JA.** Mood change and empathy decline persist during three years of internal medicine training. *Acad Med.* 2005;80(2):164-7.
117. **Coulehan J, Williams PC.** Conflicting professional values in medical education. *Camb Q Healthc Ethics.* 2003;12:7-20.
118. **Coulehan J, Williams PC.** Vanquishing virtue: the impact of medical education. *Acad Med.* 2001;76(6):598-605.
119. **Jahoda A, Wanless LK.** Knowing you: the interpersonal perceptions of staff towards aggressive individuals with mild to moderate intellectual disabilities in situations of conflict. *J Intellect Disabil Res.* 2005;49:544-51.
120. **Jain A, Ogden J.** General practitioners' experiences of patients' complaints: qualitative study. *BMJ.* 1999;318:1596-9.
121. **Cassel E.** The nature of suffering. *N Engl J Med.* 1982;306(11):639-45.